THE SIXTH ANNUAL REPORT

of the

DEPARTMENT *of* ANESTHESIOLOGY

1963

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER
525 EAST 68TH STREET, NEW YORK 21, NEW YORK

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DEPARTMENT OF ANESTHESIOLOGY

The New York Hospital
1963

by Joseph F. Artusio, Jr., M.D.

To the President of the Board of Governors of the Society of The New York Hospital:

The Department of Anesthesiology during 1963 showed marked growth in personnel, in anesthesia service, and in teaching and research.

During the past few years this department has been most active in the study of halogenated anesthetics and because of our activity in this field of chemical compounds, we were startled by the appearance of rather numerous reports concerning the hepatotoxicity of the halogenated anesthetic, Halothane. These reports were, indeed, most interesting to this department as we developed the halogenated ether, Penthrane (methoxyflurane). At this time the entire world was put on the alert with respect to the effect of the halogenated anesthetics on the liver.

These new nonflammable anesthetic agents have been heralded as advances in anesthetic drugs. In spite of our enthusiasm in this field we adopted a conservative position and eliminated the use of all of the halogenated compounds in patients with pre-existing liver disease, for surgery of the right upper quadrant, and repeated administrations during the same hospital admission. We became a part of a national retrospective study conducted by the National Academy of Science in order to determine whether the effect of the halogenated drugs on the liver was real or whether the hepatic damage that had been produced was related to other toxic substances unrelated to the simultaneous administration of the halogenated anesthetic. I believe that during 1964 the perplexing problem will be definitely settled but the fate of the halogenated compounds as anesthetic agents really hangs in the balance.

A survey committee of the American Society of Anesthesiologists during 1963 reported that anesthesiology as a specialty in the practice of medicine had achieved the status it so earnestly worked for during the past twenty years. However, the image of the anesthesiologist among his colleagues and the laity has to be improved. Steps are being taken so that in 1964 the image of the anesthesiologist should be crystalized, and I trust a good image will emerge.

Members of this department traveled into South America introducing the halogenated anesthetics to Colombia. We also aided in establishing the new section of anesthesiology of the Pan-Pacific Surgical Association meeting in Honolulu, Hawaii. A closed circuit television program emanated from this hospital to the new Hilton Hotel as part of the 17th Postgraduate Assembly of the New York State Society of Anesthesiologists and highlighted many of the recent advances in the practice of anesthesia.

We spread medical information over many miles of this globe and as subsequent sections of this report will show, have trained a considerable number of new physicians in this specialty, whose training and competence have been well demonstrated.

Our new anesthesia research facility is now completely equipped and in operation. We hope in this area fundamental research in anesthesiology will emerge.

SENIOR STAFF

My associates in the administration of this Department have been:

Benjamin E. Marbury, M.D., Attending Anesthesiologist	January 1949
Marjorie J. Topkins, M.D., Associate Attending Anesthesiologist . .	July 1952
*Robert I. Schrier, M.D., Associate Attending Anesthesiologist . . .	October 1956
Alan Van Poznak, M.D., Associate Attending Anesthesiologist . . .	February 1958
Herbert Erlanger, M.D., Assistant Attending Anesthesiologist . . .	June 1957
Francis M. Tiers, M.D., Assistant Attending Anesthesiologist . . .	August 1959
George R. Monahan, M.D., Assistant Attending Anesthesiologist . .	July 1960
Jerold Schwartz, M.D., Assistant Attending Anesthesiologist . . .	October 1961
Jerome Weinroth, M.D., Assistant Attending Anesthesiologist . . .	December 1961
Ann Huston, M.D., Assistant Attending Anesthesiologist	January 1962
Raymond G. Barile, M.D., Assistant Attending Anesthesiologist . .	July 1963
Louis J. Maggio, M.D., Assistant Attending Anesthesiologist	July 1963
Patricia M. O'Neil, M.D., Assistant Attending Anesthesiologist . .	July 1963
Barnett J. Junker, M.D., Assistant Attending Anesthesiologist . . .	October 1963

*resigned July 1963

The number of our senior staff continues to increase. However, we are fast approaching the saturation point that we will be completely staffed with Board certified or Board qualified anesthesiologists. At this time, ten Board certified anesthesiologists and four Board qualified anesthesiologists assisted me in administering this department.

During the year Dr. Robert I Schrier resigned his appointment as Associate Attending Anesthesiologist to join the Department of Anesthesiology of the Yale Medical School. Dr. Schrier contributed greatly to the growth of this department during his seven years of service. He established the anesthetic record that we currently use in this department; he represented us on the Formulary Committee and the Record Committee. His over-all supervision of the anesthetic equipment in this department provided us with the excellent working tools which has made our fine clinical service possible. The department will miss him but we certainly hope he has a most pleasant association with his new colleagues at the Yale Medical School.

Drs. Benjamin E. Marbury and Marjorie J. Topkins assumed the responsibility for all clinical service. This, indeed, is a large undertaking as our service extends throughout this huge institution, not only in the operating rooms but also into the clinics and into the diagnostic laboratories. That this service functions so smoothly is a credit to their ability. Dr. Marbury represents us on the Operating Room Committee, Record Committee, Emergency Room Committee, and the Legal Affairs Committee. Dr. Topkins represents us on the Private Patients Committee, Out-Patients Committee, and the Professional Services Committee.

Dr. Alan Van Poznak began his second year in basic research in pharmacology under the direction of Dr. Walter Riker. His studies of the nerve terminal made during these last two years in the Department of Pharmacology, I am sure, will be a significant contribution to this specialty and lead him to further work in this field.

Dr. Francis M. Tiers continues as charge of the Out-Patient Nerve Block Clinic and conducts the nerve block course for the second year residents.

In addition to his clinical duties, Dr. Herbert Erlanger took on the retrospective study of the effects of halogenated anesthetics on the liver. This data will be forthcoming during 1964.

Drs. George R. Monahan, Jerold Schwartz, Jerome Weinroth, and Ann Huston, along with their clinical service, aided us with the resident teaching.

This year marked the largest number of new attending anesthesiologists to join this department. When Drs. Raymond G. Barile, Louis J. Maggio, and Patricia M. O'Neil completed their residency training at this institution, they joined the senior staff. Dr. Barnett J. Junker, the latest addition to our attending staff, joined us from the Department of Anesthesiology of the New York University Medical College and has become an intrigal part of this department.

RESIDENT STAFF

Resident staff appointments in Anesthesia for the year 1963 are as follows:

First Year Residents

Charles Akselrad, M.D.	July 1, 1961 to June 30, 1963
Raymond G. Barile, M.D.	July 1, 1961 to June 30, 1963
Phyllis Bagdi, M.D.	July 1, 1961 to June 30, 1963
Philip Freedman, M.D.	July 1, 1961 to June 30, 1963
Raymond Hicks, M.D.	July 1, 1961 to June 30, 1963
Louis J. Maggio, M.D.	July 1, 1961 to June 30, 1963
Patricia M. O'Neil, M.D.	July 1, 1961 to June 30, 1963
Alexander Gotta, M.D.	July 1, 1962
Luke Kitahata, M.D.	July 1, 1962
Hugh O'Shaughnessy, M.D.	July 1, 1962
Krystyna Szmurlo, M.D.	July 1, 1962
Colleen Sullivan, M.D.	July 1, 1962
Miriam Tani, M.D.	July 1, 1962

First Year Assistant Residents

Mary Ellen Cooney, M.D.	July 1, 1963
Aileen Kass, M.D.	July 1, 1963
Joseph Moccia, M.D.	July 1, 1963
Parvaneh Modaber, M.D.	July 1, 1963
David Susman, M.D.	July 1, 1963
*Josefina Pison, M.D.	July 1, 1963 to Oct. 31, 1963
*Arthur Poole, M.D.	Mar. 1, 1963 to June 30, 1963
Patricia Kennedy, M.D.	Nov. 1, 1963 to Dec. 31, 1963
*Enrique Panlilio, M.D.	Nov. 1, 1963

*Four months training as per agreement with Memorial Hospital.

Again, we can say that this year marked the largest number of residents in training in the Department of Anesthesiology at the New York Hospital.

Of the twenty-two young physicians who received all or part of their training at this institution during 1963, none were graduates of the Cornell University Medical College. I have been concerned for many years because we do not attract more of our own Cornell graduates to our residency training program. There was a time when 80% of our trainees were from Cornell University Medical College. This gradually fell to 33%, down to 10%, and this year, to 0%. This is in spite of a much enlarged teaching program for the medical students in each year of their medical school training. Perhaps, we here too, at the New York Hospital have to improve our own image in respect to our own medical students.

On July 30 of this year, Drs. Charles Akselrad, Raymond G. Barile, Phyllis Bagdi, Philip Freedman, Raymond Hicks, Louis J. Maggio, and Patricia M. O'Neil completed their residency training program at this institution. Dr. Charles Akselrad continued in clinical anesthesia at Brooklyn Hospital. Dr. Phyllis Bagdi, in concurrence with this department, went to the Virginia Mason Clinic in Seattle, Washington to take a third year in anesthesia training, primarily to increase her efficiency in nerve block therapy. Dr. Philip Freedman went on for a third year of training at Mount Sinai Hospital in this city. Dr. Raymond Hicks became the chief of anesthesia at the Veterans Hospital in Tuskegee, Alabama and is developing his own residency training program at that institution. Drs. Raymond G. Barile, Louis J. Maggio, and Patricia M. O'Neil joined the senior staff of our department.

Drs. Alexander Gotta, Luke Kitahata, Hugh O'Shaughnessy, Krystyna Szmurlo, Colleen Sullivan, and Miriam Tani moved into their advanced year of anesthesia training.

We welcomed Drs. Mary Ellen Cooney, Aileen Kass, and Parvaneh Modaber, graduates of the New York Medical College; Dr. Joseph Moccia, a graduate of the University of Bologna; Dr. David Susman, a graduate of Queens University Faculty of Medicine in Queens University, Canada; and Dr. Patricia Kennedy, a graduate of the Boston University Medical College. All of these people have functioned well during the first six months of training. Dr. Patricia Kennedy after her brief stay resigned as she felt anesthesiology was not the specialty for her particular attributes.

Drs. Arthur Poole, Josefina Pison, and Enrique Panlilio spent four months in this department as resident anesthesiologists as part of the four months training according to the agreement with Memorial Hospital to complete their two-year residency training program. We believe they profited by their experience with us.

NURSE ANESTHETISTS

Dr. Marjorie J. Topkins, M.D. in charge

Nurse anesthetists for the year 1963 are as follows:

Sara Mullin, Senior Nurse Anesthetist	Sept. 1932
Josephine Cahill, Senior Nurse Anesthetist	Nov. 1943
Ethel Kovar, Senior Nurse Anesthetist	Nov. 1935
Grayce Eveleth, Staff Nurse Anesthetist	Nov. 1935
Catherine Litzen, Staff Nurse Anesthetist	April 1937
Mary Sullivan, Staff Nurse Anesthetist	May 1948 to May 1963
Elizabeth Davis, Staff Nurse Anesthetist	Feb. 1958
Maureen Maxfield, Staff Nurse Anesthetist	Feb. 1958
Consuela Hansen, Staff Nurse Anesthetist	Nov. 1958
Anne Marie Ryan, Staff Nurse Anesthetist	Sept. 1959 to June 1963
Martha Chan, Staff Nurse Anesthetist	Sept. 1960 to June 1963
Barbara Frisch, Staff Nurse Anesthetist	Jan. 1961
Lowell J. Barker, Staff Nurse Anesthetist	Mar. 1961 to July 1963
Peggy A. Shackelford, Staff Nurse Anesthetist	June 1961 to Feb. 1963
Virginia Medina, Staff Nurse Anesthetist	Oct. 1962 to Mar. 1963
Carole Ann White, Staff Nurse Anesthetist	Mar. 1963
Elizabeth Ann Hambly, Staff Nurse Anesthetist	Sept. 1963

In May 1963 Miss Mary Sullivan died after a prolonged illness and a gallant fight. Miss Sullivan had been a nurse anesthetist in this department for fifteen years. A graduate of Mount Sinai School of Nursing, she completed her anesthesia training at the Long Island College Hospital. Upon completion of her training, she came to the New York Hospital. She will be missed by all of us.

Miss Ann Marie Ryan left our department to work in the state of Washington. Mrs. Chan and Mrs. Medina both resigned to have babies, and Miss Barker is now on the hospital ship Hope in Ecuador.

At the end of 1963 three senior nurse anesthetists and eight staff nurse anesthetists functioned in this department. Although this group is somewhat smaller than that of past years, through their competence and efficiency the anesthesia department was able to provide complete anesthesia coverage throughout the entire hospital. The nurse anesthetists are a vital part of this department through their conduct of anesthesia and their assistance to our anesthesiologists in clinical duties.

FUNCTIONS OF THE DEPARTMENT OF ANESTHESIOLOGY

BENJAMIN E. MARBURY, M.D. in charge

Clinical Service

In previous years the overwhelming number of anesthesias administered by this department has been to in-patients for the purpose of completing a surgical or obstetrical procedure. Certain procedures which were wholly diagnostic in nature have been done in the past that required general anesthesia but during the past year or two this type of procedure has greatly increased. Not only has there been an actual increase in the total number of anesthetics administered but also a remarkable increase in the number of different medical specialties employing anesthesia for diagnostic studies. This great demand for anesthesia for diagnostic and non-operative procedures carried out, some using x-ray control, has increased so markedly in 1963 that the department is now anesthetizing a significant number of patients in areas outside of the operating rooms. Most of these procedures are in areas that are not free of explosive hazards and therefore, the employment of anesthetic agents without flammable or explosive limits has increased. During the past year, 175 halothane, 1149 methoxyflurane, and two trichlorethylene (Trilene) anesthesias, as part of non-explosive techniques, accounted for one-fifth of the total anesthesias administered during 1963.

The demand for clinical service continues in the area of consultation for emergency resuscitation throughout the hospital and for all services. This service is supplied for all patients on a 24-hour emergency basis and assistance to these patients during catastrophic events has proven to be lifesaving in many instances.

RESIDENCY TRAINING

The training of the resident in anesthesia has continued along the lines that we have detailed in previous reports of this department. Starting the resident's training with very fundamental concepts and the administration of single anesthetic agents develops his foundation in the physiology and the pharmacology of anesthesia simultaneously with the clinical administration of anesthetics, from simple to eventually complex techniques in patient management. This program continues unabated throughout the first year of training. This is accomplished by daily administration of anesthetics and daily attendance at seminars conducted by a member of the senior staff.

The second year of training has been a continuation in the administration of clinical anesthesia, and the resident perfecting his anesthetic techniques and developing his clinical judgment in the care of the anesthetized patient. This is the year in which the resident is allowed to romance a bit in the administration of anesthesia, but he must be able to justify his choice of agent and technique. The didactic program has not been as intense as it had been in the first year of training and has been limited primarily to a course in nerve block associated with cadaver dissection. However, this year for the first time, through the efforts of Dr. Francis M. Tiers, the teaching schedule of a didactic nature for the second year residents has indeed improved. Beginning in July 1963 a series of didactic seminars on the general subject of body fluids was conducted. Drs. Francis M. Tiers, George R. Monahan, Herbert Erlanger, and Jerold Schwartz participated in the first three months of training. The seminars covered such various topics as the composition of body fluids, body fluids in disease, pH, congestive heart failure, renal failure, pituitary and thyroid disease, and pediatric fluids. This proved very rewarding for the second year residents and I would believe that we will continue this second year training program during 1964.

The second three months was occupied with the nerve block course and experience in the administration of nerve blocks.

The second six months of training, which will extend into 1964, covers the unusual disease states and unusual surgical situations. Among the topics to be discussed are pheochromocytoma, thyroid toxicosis, crush chest, anesthesia for heart surgery, anesthesia for surgery of the lungs, anesthesia for plastic surgery, etc. Also included in this series of lectures are discussions on the background and tools for modern basic science research in anesthesia and some thoughts on the future of clinical anesthesia and the future of anesthesia research.

This increase of seminar teaching, we believe, will improve our training program. Although we are pleased with the product that this program has produced, we are always looking for ways to improve the training of the physician in the specialty of anesthesiology.

This type of anesthesiology training program keeps the resident working, searching, and studying throughout his two years of training. It is an attempt to maintain a pace where achievement of clinical excellence is associated with an achievement of a wide body of fundamental knowledge of the specialty.

MEDICAL STUDENT TRAINING

During 1963 we have continued to give didactic lectures to the third year medical student and demonstrations in practical anesthesia during the fourth year. The elective course in the fourth year has remained popular and we continue to have a good number of students who are electing anesthesiology as their second year elective. We are encouraging those medical students who will be taking a rotating internship that their time would be well spent if they devoted a part of their rotation in the field of anesthesiology. We do this because we feel that the experience in handling the unconscious patient and experience in cardiac and respiratory resuscitation will be an excellent part of their training regardless of whether or not they become anesthesiologists.

If anesthesiology is to maintain the great strides that it has achieved in the past twenty years, it must continue to show to the medical student contributions that the specialty of anesthesiology makes to patient care. The need for anesthesiologists throughout the country is tremendous. It is the job of the medical schools of this country to make the student aware of this particular practice of medicine. So that he considers it amongst his choices of a specialty when he makes the final decision as to which area of medicine he will devote his life's work. Frequently, the medical student, even today, has such little association with the department of anesthesiology that he does not consider it when he chooses his specialty. We hope that this is not true of the Cornell medical student. We hope we ever increase his contact with anesthesiologists. Every effort was made this year to do just this and we know these efforts will increase in intensity in the ensuing years.

We are also attempting to interest the medical student in summer research scholarships in anesthesiology. This direct contact with the department of anesthesiology functioning in a capacity similar to a resident anesthesiologist, we believe, will provide the insight into the entire specialty, may attract medical students who would not be attracted by other than this means.

INSTRUMENTATION AND RESEARCH FUNCTION

Alan Van Poznak, M.D. in charge

During 1963 the department continued to provide the services in monitoring physiologic variables during cardiopulmonary bypass for open heart surgery and profound hypothermia with bypass in neurosurgery.

Further clinical work with methoxyflurane has defined its usefulness among the other anesthetic agents. This nonflammable ether was investigated in the animal laboratories of Cornell University Medical College and given its first clinical trial in the New York Hospital in 1959.

A second nonflammable agent resembling cyclopropane in its clinical properties is awaiting further animal testing before receiving widespread clinical trial. Should this agent, Teflurane, be acceptable for clinical use, we will have practically eliminated the explosion hazard in anesthetic practice.

A well furnished laboratory for anesthesia research has been provided on the 6th floor of the Medical College. This much-needed space will greatly facilitate research work.

Dr. Van Poznak has continued his work in the Department of Pharmacology studying the effects of cyclopropane on skeletal muscle and motor nerve terminal.

It is hoped that the department will be able to develop a research training program for qualified candidates who have completed their residencies in anesthesiology. Anesthesiology, perhaps more than any other specialty, is directly founded on physiology and pharmacology. Significant research advances can be made by applying the principles and techniques of these basic sciences to research problems in anesthesiology. However, few anesthesiologists engaged in research have had the opportunity to return to basic science programs to receive the training which will enable them to pursue their research activities more effectively. The development of such a program will depend upon close working relationships with the basic science departments. Fortunately, such a relationship has existed with the Department of Pharmacology for many years and has given use to studies in the field of neuromuscular transmission, muscle relaxants, and curare antagonists. It is hoped that other basic science departments will participate as the purpose grows.

RECORDS AND STATISTICS

Chart I

Chart I indicates that the total number of anesthetics administered in this hospital increased approximately by 400 during 1963. It is interesting to note that 119 were given for electroconversion of abnormal cardiac rhythms; this procedure is approximately one year old at this institution.

Nonflammable, nonexplosive halogenated hydrocarbons increased by more than 300 cases during 1963 at the expense of the number of cyclopropane and spinal anesthesias given.

Chart II

Chart II shows that the methods of anesthetic induction were very similar to those in 1962. However, we have increased the use of the semi-closed circle CO_2 absorption technique rather than the closed circle CO_2 absorption technique. I believe this is due to the increase in the administration of the halogenated anesthetics, which for the most part are now used by the semi-closed technique.

Cardiopulmonary bypass and generalized hypothermia increased by 25% during 1963. It is interesting to note that during 1963 the neuromuscular blocking agents decreased by more than 250 administrations and was most likely due to the administration of Penthrane (methoxyflurane) when muscle relaxation is usually adequate without the use of a peripheral muscle relaxant.

Chart III

Surgery by region is self-explanatory. It is interesting to note that most of our operations are in the lower abdomen; the next highest incidence was surgery of the peritoneum; and head and neck procedures took the third position.

Chart IV

The resident anesthesiologists performed one-third of the anesthetics given in the hospital, which is a considerable increase from last year.

Chart V

Chart V (a) indicates that the cardiac arrests numbered seven. Six of the seven were considered extremely poor anesthetic risks prior to anesthesia and surgery and were in the fifth decade of life or later. It is interesting to know that of the seven cardiac arrests, five had successful cardiac resuscitations. Three of these five subsequently died and two recovered without sequelae.

In two instances, cardiac resuscitation was ineffective to restore cardiac action. One of the two was due to massive hemorrhage from a ruptured aneurysm; the other, following a litgation of a coronary artery.

Six of the seven patients had received a muscle relaxant and three of the seven patients received cyclopropane.

Chart V (b) shows that eleven patients sustained myocardial infarction. Four of these patients went on to improvement and seven died by the fifth postoperative day. Of all these patients who sustained a myocardial infarction, only two of them were considered a good risk prior to anesthesia and surgery, and these two occurred following cholecystectomy.

Of the seven patients who died, three had a history of angina pectoris and four had a previous myocardial infarction. The four patients with previous infarctions succumbed to the myocardial infarction following surgery.

Chart V (c) indicates that three of our patients sustained pulmonary infarctions; one patient succumbed to the pulmonary infarction.

Four patients developed cerebral thrombosis; however, only one succumbed to the cerebral thrombosis.

Statistical data for this report was accumulated from our anesthetic records and compiled by Miss Sara Mullin and Miss Grayce Eveleth.

1963

Department of Anesthesiology

General Surgery — GYN — Obstetrics

Cyclopropane	6,674	
Ether, semi-closed	1,553	
Ether, open	295	
Nitrous Oxide	4,009	
Intravenous Pentothal	50	
Rectal Pentothal	11	
Vinethene	37	
Regional block for surgery	60	
Spinal	192	
Epidural and caudal	24	
Fluothane	1,755	
Penthrane	1,149	
Fluomar	1	
Trilene	1	15,811

Miscellaneous

Locals	3,463	
Blocks O. R. and Clinic (therapeutic and diagnostic)	11	
Locals Clinic	406	
Adjuvants, electroshock therapy	190	
Adjuvants, electroconversion	119	4,189
		20,000
Private patients	11,762	
Pavilion patients	8,238	20,000

Chart I—Annual Summary—Primary Anesthetics

1963

Department of Anesthesiology

General Surgery — GYN — Obstetrics

Methods of induction to primary anesthesia

Intravenous pentothal induction	9,732
Vinethene induction	155
Rectal pentothal basals	69

Induction and maintenance with same anesthetic

Cyclopropane induction to Cyclopropane maintenance	690
Ether induction to Ether maintenance	266
Nitrous oxide induction to Nitrous oxide maintenance	2,965

Technics

Closed circle CO_2 absorption technic	8,646
Semi-closed circle CO_2 absorption technic	6,325
Open mask method	230
Insufflation	76
Infant circle CO_2 absorption technic	196
Mechanical ventilator	65
Non-breathing valve	18

Special technics

Arfonad — controlled hypotension	37
Cardiac-pulmonary bypass	66
Generalized hypothermia (tub or blanket)	59
Localized hypothermia (ice packs)	52

Endotracheal intubation

Nasoendotracheal	168	
Oroendotracheal	5,660	5,828

Neuromuscular blocking agents

d'tubocurarine only	215	
Succinylcholine only	5,142	
Both used	721	
Flaxedil only	62	6,140

Chart II—Annual Summary—Methods of Induction—Technics—Special Drugs

1963

ANESTHESIOLOGY DEPARTMENT

Summary of Cases — Includes General, Spinal and Block Anesthesia

Head and Neck

ENT (by region)	772
Eye	569
Dental	122
Face	125
Thyroid	160
Neck	144
Head, superficial	16
Intracranial	238
Esophagoscopy Bronchoscopy	73
	2,219

Thorax

Great vessels	20
Mitral valvulotomy (closed)	34
Cariac-Pulmonary bypass	66
Other heart surgery	37
Intrapleural	159
Thorax, superficial	533
Thoracic cage	5
Shoulder	24
Thoracic sympathectomy	1
	879

Upper abdomen

Stomach-duodenum	252
Biliary tract	549
Retroperitoneal	44
Colon	333
Pancreas	21
Spleen	30
Renal	223
Portal	11
Close evisceration	6
	1,469

Lower abdomen

Appendix	258
Bowel, small	104
OB, vaginal delivery	3,737
GYN, abdominal surgery	668
Urology, adbominal	341
Caesarean section	234
Abdominal-perineal	46
Abdominal aorta & branches	75
Ventral hernia	54
Negative exploration	1
	5,518

Abdominal wall

Extraperitoneal	8
Hernia, ing.fem.umb.	583
Lumbar sympathectomy	19
Abdomen, superficial	47
Burns, 10% body	3
	660

Perineal

GU perineal (TUR & Cysto)	1,314
Ano-rectal	211
Perineal GYN (D&C, etc.)	2,326
Vaginal hysterectomy	127
	3,978

Spine

Column	72
Cord	29
Back, pilonidal, etc.	74
	175

Limbs

Upper bone	64
Upper soft	224
Lower bone	326
Lower soft	284
	898

Grand total operations	15,796
Grand total anesthesias	15,811
Anesthesia—no operation	15

CHART III

1963

ANESTHESIOLOGY DEPARTMENT

Summary of RESIDENT Anesthesiologists' Cases
Includes General, Spinal and Block Anesthesias

Head and Neck

ENT (by region)	367
Eye	197
Dental	77
Face	28
Thyroid	65
Neck	64
Head, superficial	7
Intracranial	78
Esophagoscopy Bronchoscopy	42
	925

Thorax

Great vessels	15
Mitral valvulotomy (closed)	29
Cardiac-Pulmonary bypass	63
Other heart surgery	34
Intrapleural	66
Thorax, superficial	103
Thoracic cage	5
Shoulder	4
Thoracic sympathectomy	0
	319

Upper Abdomen

Stomach-duodenum	114
Biliary tract	214
Retroperitoneal	10
Colon	116
Pancreas	6
Spleen	13
Renal	106
Portal	5
Close evisceration	4
	588

Lower Abdomen

Appendix	123
Bowel, small	47
OB, vaginal delivery	880
GYN, abdominal surgery	179
Urology, abdominal	123
Caesarean section	79
Abdominal-perineal	25
Abdominal aorta & branches	35
Ventral hernia	28
Negative exploration	1
	1,520

Abdominal wall

Extraperitoneal	3
Hernia, ing.vem.umb.	210
Lumbar sympathectomy	11
Abdomen, superficial	8
Burns, 10% body	1
	233

Perineal

GU perineal (TUR & Cysto)	353
Ano-rectal	42
Perineal GYN (D&C, etc.)	597
Vaginal hysterectomy	51
	1,043

Spine

Column	14
Cord	14
Back, pilonidal, etc.	20
	48

Limbs

Upper bone	20
Upper soft	81
Lower bone	165
Lower soft	88
	354

Grand total operations	5,030
Grand total anesthesias	5,040
Anesthesia—no operation	10

CHART IV

ANESTHESIOLOGY CLASSIFICATION OF COMPLICATIONS

Age in Decades	*Physical Status*	*Agent*	*Technic*	*Relaxant*	*Diagnosis-Operation*	*Anes. Ind. to Arrest*	*Complication*	*Result*
6th	3	Ether	S. Closed	....	Ischemia hand ¢ gangrene. Incision brachial artery; Exc. distal index finger	1 hr.	Cardiac arrest O.R. Preop. ASCVD ¢ mild angina and mitral insufficiency.	Success resus; no sequelae
7th	2	Cyclo	Closed Endotr.	Anectine	Carcinoma urinary bladder. Radical cystectomy, ileal conduit.	10 hrs.	Cardiac arrest R.R. Preop. LVH Po. hypotension	Success resus. Death 1st po. day
6th	2	Cyclo	Closed Endotr.	Anectine Curare	Arteriosclerotic obliterans. L. aortico-iliac ¢ aortico-femoral bypass.	9 hrs.	Cardiac arrest O.R. After aorto unclamped	Success resus. Death 1st po. day
9th	3	Cyclo	Closed Endotr.	Anectine	Carcinoma of rectum; diverticulosis colon. Abdominal peri-rectal coloproctectomy.	4 hrs.	Cardiac arrest O.R. and again 12 hrs. po. 1° heart block preop.	Success resus. Death 1st po. day
2nd	3	Fluothane	S. Closed Endotr.	Anectine	Anomalous origin left coronary artery. Ligation same	2 hrs.	Cardiac arrest R.R. Prev. digitalized for CHF.	Cardiac resus. Death
5th	3	Ether	S. Closed Endotr.	Anectine	Acute cholecystitis Cholecystectomy	40 min.	Cardiac arrest O.R. Preop. HCVD ¢ angina cardiomegaly.	Success resus; no sequelae
6th	6	Penthrane	Closed Endotr.	Anectine	Dissecting thoracic aortic aneurysm. Exp. thorax and dissecting aortic aneurysm.	3 hrs.	Cardiac arrest O.R. Rupture aneurysm	Cardiac resus. Death

Chart V (a) — Cardiac Arrests & Massage

ANESTHESIOLOGY CLASSIFICATION OF COMPLICATIONS

Age in Decades	*Physical Status*	*Agent*	*Technic*	*Relaxant*	*Diagnosis-Operation*	*Anes. Time*	*Complication*	*Result*
7th	3	Cyclo	Closed Endotr.	Anectine	Carcinoma of rectum ASCVD, severe ¢ angina Adm.dx., impending MI Anterior resection of colon	4½ hrs.	Myocardial infarct 4th po. day	Death
7th	3	Cyclo	Closed Endotr.	Anectine	Metas. ca. rectum; uremia Obesity; ASCVD Ureteroureterostomy	5 hrs.	Myocardial infarct 1st po. day	Death
6th	2	Cyclo	Closed Endotr.	Anectine	Carcinoma sigmoid colon ASHCVD ¢ angina pectoris Ant. resection sigmoid colon	3 hrs.	Myocardial infarct	Improved
9th	3	Nitrous	S. Closed	....	Intertrochanteric fract. hip ASCVD ¢ chr. brain syndrome Senile; emphysema Jewett nailing left hip	2 hrs.	Myocardial infarct 2nd po. day	Death
9th	2	Penthrane	Closed Endotr.	....	Subcapital fracture hip ASCVD ¢ old MI; HCVD ¢ arteriolar nephrosclerosis Replace L. hip ¢ prosthesis	1½ hrs.	Myocardial infarct 1st po. day	Death
7th	3	Cyclo	Closed Endotr.	Anectine	Chronic cholecystitis & cholelithiasis Angina pectoris Cholecystectomy	2 hrs.	Myocardial infarct 5th po. day	Death

CHART V(b) — Vascular Complications

ANESTHESIOLOGY CLASSIFICATION OF COMPLICATIONS

Age in Decades	*Physical Status*	*Agent*	*Technic*	*Relaxant*	*Diagnosis-Operation*	*Anes. Time*	*Complication*	*Result*
7th	3	Cyclo	Closed Endotr.	Anectine	Multiple polyps of stomach Mild heart failure-digitalized Subtotal gastrectomy; gastroenterostomy.	3 hrs.	Myocardial infarct 4th po. day	Improved
7th	1	Cyclo	Closed Endotr.	Anectine Gallamine	Chronic cholecystitis Cholelithiasis Cholecystectomy & drainage	2½ hrs.	Myocardial infarct operative day	Improved
8th	3	1. Cyclo 2. Pent N2O	Closed Endotr. S. closed	Anectine	Carcinoma left breast Old MI; old CVA ¢ aphasia Senile emphysema 1. Modified radical mastectomy 2. removal rt. big toe nail	1. 2 hrs. 2. 20 min.	Myocardial infarct 1st po. day after 2nd operation	Death
7th	3	Spinal Pent.	S. closed	....	Diabetic gangrene left foot Previous MI x 3 Left mid-thigh amputation	1½ hrs.	Myocardial infarct 3rd po. day and 10th po. day	Death
7th	2	Cyclo	Closed Endotr.	Anectine	Chronic cholecystitis ¢ choledocholithiasis. Hypothyroidism & hypoparathyroidism. Hypertension. Cholecystectomy & choledocholithotomy	3 hrs.	Myocardial infarct 3rd po. day and renal failure	Death
6th	1	Cyclo	Closed Endotr.	Anectine Curare	Chronic cholecystitis ¢ cholelithiasis. Cholecystectomy	2½ hrs.	Myocardial infarct 1st po. day	Improved

Chart V(b) — Vascular Complications

ANESTHESIOLOGY CLASSIFICATION OF COMPLICATIONS

Age in Decades	*Physical Status*	*Agent*	*Technic*	*Relaxant*	*Diagnosis-Operation*	*Anes. Time*	*Complications*	*Result*
7th	2	1. N_20 2. Cyclo	S. closed Closed	Anectine Anectine	Hypertension; history thrombophlebitis arm & leg 2½ mo. preop. Cyst right kidney 1. Cystoscopy ¢ retrogrades 2. Exp. rt. kidney; wedge resect.	2 hrs.	Pulmonary infarct 5th po. day	Death
8th	2	Fluothane	S. closed	....	Subcapital fracture rt. hip Closed reduction-fixation same	2 hrs.	Pulmonary infarct 1st po. day	Improved
4th	2	Cyclo	Closed Endotr.	Anectine	Chr.cholecystitis; cholelithiasis Cholecystectomy & CD exploration	3 hrs.	Pulmonary infarct 3rd po. day	Improved
5th	2	Penthrane	Closed Endotr.	....	Mitral stenosis Open mitral valvulotomy	5 hrs.	Cerebral thrombosis 1st po. day	Improved
4th	3	Ether	S. closed	....	Mitral stenosis Mitral valvulotomy	3 hrs.	Cerebral thrombosis in Recovery Room	Improved
8th	3	1. Local 2. Spinal	....	....	Arteriosclerosis obliterans Gangrene left great toe 1. Amputation L. great toe 2. L. mid-thigh amputation	1 hr. 1½ hrs.	Cerebral thrombosis 3rd po. day	Death
8th	4	Penthrane	Closed Endotr.	Anectine	HASCVD-Complete heart block Insertion cardiac pacemaker	3 hrs.	Cerebral thrombosis operative day	Improved

CHART V(b) — Vascular Complications

ANESTHESIOLOGY CLASSIFICATION OF COMPLICATIONS

Age in Decades	*Physical Status*	*Agent*	*Technic*	*Relaxant*	*Diagnosis-Operation*	*Anes. Time*	*Complication*	*Result*
6th	3	Cyclo	Closed Endotr.	Anectine	History MI x 3 — CHF digitalized, compensated Carcinoma prostate Suprapubic cystostomy; bilat. orchiectomy.	1 hr.	Pulmonary edema O. R.	Improved
6th	4	Cyclo	Closed Endotr.	Anectine	Bleeding duodenal ulcer 1. Subtotal gastrectomy 2. Re-resection of stomach, plication bleeding stump	1. 4½ hrs. 2. 8½ hrs.	Pneumonitis from aspiration blood 1st po. day, 1st op.	Improved
8th	2	Cyclo	Closed Endotr.	Anectine	Leiomyoma of stomach, bleeding Subtotal gastrectomy	5 hrs.	Atelectasis, pneumonia 2nd po. day	Improved
2nd	1	Fluothane	S. closed Endotr.	Anectine	Rt. hydrocele, inguinal Mild URI Right hydrocelectomy	1 hr.	Aspiration po. in O.R.-pneumonitis 1st po. day	Improved
5th	2	Fluothane	S. closed Endotr	Anectine	Hashimoto's disease thyroid Thyroidectomy	2½ hrs.	Lobar pneumonia 4th po. day	Improved
2nd	1	Cyclo	Closed Endotr.	....	Triplicated L. upper urinary tract; ureterocele. Re-implant double L. ureters; exc. ureterocele	4 hrs.	Aspiration O. R. pneumonia 1st po. day	Improved
5th	1	1. Ether 2. Local	S. closed Endotr.	Anectine Curare	Chr. cholecystitis; cholecysto-duodenal fistula. 1. Cholecystectomy; CD exp; close duodenal fistula. 2. Bronchoscopy	5 hrs.	Atelectasis Pneumonitis 1st po. day	Improved

CHART V (c) — Pulmonary Complications

ANESTHESIOLOGY CLASSIFICATION OF COMPLICATIONS

Age in Decades	*Physical Status*	*Agent*	*Technic*	*Relaxant*	*Diagnosis-Operation*	*Anes. Time*	*Complication*	*Result*
7th	1	Cyclo	Closed Endotr.	Anectine	Chronic cholecystitis & cholelithiasis; Hypertension Cholecystectomy	2 hrs.	Bronchopneumonia 3rd po. day	Improved
3rd	2	Cyclo	Closed Endotr.	Anectine	HCVD—Coarctation of aorta Ligation of patent ductus Resection coarctation aorta	6 hrs.	Atelectasis, rt., pneumonia, 1st po. day	Improved
5th	1	Cyclo	Closed Endotr.	Anectine Curare	Chr. duodenal ulcer ¢ pyloric obstruction. Pyloroplasty; vagotomy	2 hrs.	Pneumonia LLL 3rd po. day	Improved
5th	2	Fluothane	S. closed Endotr.	Anectine	Nodular goiter Emphysema preop. Subtotal thyroidectomy	3 hrs.	Pneumonia RLL 1st po. day	Improved
4th	2	Ether	S. closed Endotr.	Anectine	Left hydronephrosis Left nephrectomy	3 hrs.	Aspiration in RR atelectasis and bronchopneumonia 1st po. day	Improved
6th	2	Ether	S. closed Endotr.	....	L. U-P junction obstruction & hydronephrosis L. pyeloplasty; nephrostomy	2 hrs.	Bronchopneumonia LML—1st po. day	Improved

Chart V (c) — Pulmonary Complications

CLOSING COMMENTS

The sixth year of the Department of Anesthesiology was marked by an increase in the number of attending and resident anesthesiologists. The attending anesthesiologists have improved the clinical administration of anesthetics to our patients and the increased number of resident anesthesiologists has given us the opportunity to train a larger number of individuals in this specialty.

Research has proceeded along planned lines and the number of anesthetics administered have increased during 1963.

We believe we have demonstrated steady growth this year and look forward to continued growth and accomplishment for the future.

Joseph F. Artusio, Jr., M.D.
Anesthesiologist-in-Chief

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